Frequently Asked Questions

Frequently Asked Questions (FAQ)s have been sent to the State CMS Branch for statewide distribution via the website. The questions have been separated into **SYSTEMS** (the " how to" portion of the questions), **POLICY** (new policies or issues that have come to our attention as a result of system changes), and **DENTAL** (all issues related to dental regardless of policy or systems).

Some of the questions may overlap. The questions that have been received will generally be posted on a weekly basis. If your question has not been answered, and still needs answering, please contact the appropriate regional office.

SYSTEMS

Authorizations

1. Is it necessary to give a hospital an authorization for the contract number and for the non-contract number for Medi-Cal beneficiaries? NEW!

2. Can you briefly define Medical Home?

3. What is the current process to authorize EPSDT SS Supplemental Services through E47?

4. What codes and units do we use when authorizing emergency medical transportation?

5. If I want to authorize hearing aid batteries, it states this is an EPSDT item. Do I have to contact you every time to get approval for hearing aid batteries, or is there another way?

6. How can a retroactive SAR be issued for a child that was previously in another county?

7. Will HF-only ever populate on a SAR?

8. Who has the ability to override a 21-day NICU stay on a SAR?

9. For inpatient rehabilitation and NICU admissions, to whom should the SAR be sent? NEW!

10. Does oral Baclofen require separate authorization? NEW!

11. Can you modify a SAR on the next day? NEW!

12. Can SARs be issued for formula or TPN? NEW!

13. Can Synagis be authorized in the web-based SAR system? NEW!

14. Can a Mom's CIN be used on a claim form along with an infant's SAR number? NEW!

Claims Processing

1. Which number is more critical for payment of a claim through the E 47-automated SAR system, the SAR number or Medi-Cal provider number?

2. After June 30, 2004, will claims be denied if the CGP number is used rather than a Medi-Cal provider number?

3. Can the selection for the denial be reformatted to bullet form for easier selection?

4. Which provider number (contract or non-contract) do we use for non-Medi-Cal beneficiaries?

5. How can our dependent county invoice the State for a transplant case without seeing the claims?

6. Will we be able to view detailed paid claims information from Business Objects reports?

7. Will payment ever be linked to a CCS diagnosis in the new SARs system?

8. How is a specialist consulting on a CCS client for an outpatient dental procedure authorized? NEW!

9. Can a provider be reimbursed if the service code on the SAR does not match the code used for billing? NEW!

Durable Medical Equipment, Medical Supplies

1. Can you tell me what the different modifiers for durable medical equipment (DME) stand for?

2. When do you use the sales tax modifier for DME and if the modifier does not appear on the SAR, how will the provider know it was authorized?

3. When issuing an authorization for a wheelchair or other medical supply that will be rented for more than one month, what amount do we use in the UNITS authorized field?

4. I have a SAR for medical supplies and I am having trouble finding a code to fit the description of the request. What should I do?

5. Will the old Local Level Medi-Cal Codes for diabetic supplies be valid after November 1 for issuing authorizations and for claiming?

6. Is it possible to include diabetic supplies in a SCG? NEW!

7. How are "by report" SARs for wheelchair(s), specialized parts, and DME-R completed when there are multiple code entries required on a single SAR?

8. Can a pharmacy dispense syringes based on an authorization for insulin? NEW!

9. How are polycarbonate lenses authorized? NEW!

Provider Issues

1. Why won't the system allow us to issue a SAR to a group's Medi-Cal Provider number?

2. What can be done when the provider address listed on the SAR does not match the provider's current address?

3. Does a paneled specialist have to share the 01 SCG SAR with a non-paneled primary care physician? NEW!

4. What is a pseudo-SAR? NEW!

Service Codes, Service Code Groupings

1. What happens when we need to authorize something that is out of the service code groupings (SCG)? NEW!

2. I can locate service codes for the NICU but I am unable to locate service codes for the PICU. What can I do for the PICU authorizations?

3. When a SCG authorization is issued to a Communications Disorder Center (SCC), individual codes CANNOT be authorized on the same SAR. Correct?

4. For codes within SCG 04 that are EPSDT SS, do you check the EPSDT SS box? NEW!

DENTAL

Authorizations

1. When authorizing updated orthodontia services that were previously authorized in the legacy system, is it necessary to continue a CCS child's orthodontia authorization in the legacy system, or can a new authorization be given in the SAR system?

2. For the child who needs dental services prior to cardiac surgery, will the Denti-Cal program handle this request urgently or does the surgery need to be canceled to complete the dental work?

3. Who is responsible for the authorization of anesthesia for dental services authorized by Denti-Cal for CCS clients?

4. When we select a dentist, sometimes there is no address showing up on the SAR. What causes this?

5. How can we authorize to a dentist who does not have an individual provider number but is in a group?

6. How do I find procedure codes for authorizing "operating room facilities" for dental surgery?

7. When Denti-Cal authorizes dental or orthodontia services for CC cases, is the family eligible for Maintenance and Transportation (M&T) benefits? NEW!

Provider Issues

1. How can we get the list of Denti-Cal providers? Will the providers who did not want their name used for referrals be on the list?

2. Regarding oral surgery performed within a hospital setting, does the oral surgeon bill with his Denti-Cal or a Medi-Cal provider number?

3. When an orthodontist sends a CCS child elsewhere to get x-rays or labs done, how does the x-ray or lab provider get paid? NEW!

Service Code Groupings

1. When will Dental service code groupings (SCG) be on the website?

POLICY

Authorizations

1. How do I authorize vendored therapy (OT/PT) services in lieu of MTU?

2. How do I authorize Prosthetics and Orthotic (P&O) services?

3. How do we authorize the co-payment for patients with CCS and PPO coverage?

4. For an inpatient hospitalization involving surgery, will all professional fees be covered with the SAR authorizing the specific surgical procedure? NEW!

Provider Issues

1. Do emergency room doctors need to get paneled and if the patient is hospitalized do the services from the ER get billed through the hospital authorization?

2. If the address for the paneled provider in a group is incorrect how will it be fixed and where should we send the SAR approval?

3. What should we tell pharmacies who cannot process claims for children with Healthy Families coverage?

4. Concerning a FAQ from a prior publication: “Provider address listed on the SAR does **not** match the provider’s current address.” What action should be taken?

5. What is the status of stand-alone Emergency Room (ER) and outpatient facility codes?

6. Is paneling required for Prosthetists and Orthotists? NEW!

7. How can a SAR be issued to an Individual Nurse Provider since these nurses cannot be paneled? NEW!

Service Code Groupings

1. Service Code Groupings are very broad. How will we be certain that they are not being abused?

2. Can a descriptive sentence be added to describe each Service Code contained in a SGC?

3. How can a MRI be authorized to the imaging center providing the service? NEW!

4. Can a separate SAR for SCG 04 and for SCG 05 be issued to two different centers? NEW!

5. Does a SCG 02 SAR include the provision of a sleep study? NEW!

SYSTEMS

Authorizations

1. **Is it necessary to give a hospital an authorization for the contract number and for the non-contract number for Medi-Cal beneficiaries?**

   Effective July 30, the hospital contract number is adequate, however contract hospitals often have medical services such as blood products excluded from their inpatient per diem. These excluded services are billed by the hospital using their outpatient provider number. Counties should issue a separate SAR to the contracted hospital's outpatient provider number for any excluded services a CCS child might be expected to need during the hospitalization, including blood products for trauma or anticipated surgery. The hospital should be aware of what these services are and should be able to provide the procedure codes necessary so you can issue the SAR.

   In addition, non-contract hospitals also require a separate authorization for blood products.

2. **Can you briefly define Medical Home?**

   The Medical Home provider is commonly referred to as the Primary Care Physician. The Medical Home option should be included in the SAR distribution drop-down box in the October or November change cycle. Until then, make another copy and send it separately to the Primary Care Physician. Be sure to include this information in a narrative.

3. **What is the current process to authorize EPSDT SS Supplemental Services through E47?**

   In the September change cycle, there was a correction to allow EPSDT-SS procedure codes (Z4300-Z4315 and Z5800-Z5999) to be authorized on a SAR.

4. **What codes and units do we use when authorizing emergency medical transportation?**

   Since virtually all requests for emergency transportation will be issued after the service has occurred, the provider will be providing you with the codes for the services that were already provided. See This Computes # 68.

5. **If I want to authorize hearing aid batteries, it states this is an EPSDT item. Do I have to contact you every time to get approval for hearing aid batteries, or is there another way?**

You may now use the E47 SAR to issue authorizations for hearing aid batteries. Make sure you select either EPSDT SS or CCS SS (as appropriate) then choose "non-benefit hearing aid batteries" from the category list. This will not require state approval. Use HCPCS billing code Z5822 and enter the units that are necessary for that child's needs. (maximum of 18 batteries per quarter per hearing aid). You may refer to N.L. 18-0795 for more information regarding the authorization of hearing aid batteries for CCS children.

6. **In E-47, the only way we can get the system to allow a retroactive SAR, is to make the case opening/referral date and the date of service the same. This doesn't seem appropriate, as it doesn't reflect the actual facts as to when program eligibility was established. Also, this would skew management reports because the potential case was actually received in a given month, but would be reflected in the system for a prior month for which reports would already have been generated.**

   We made a change in CMS Net because users were able to cancel and deny authorizations for clients that were not in their county or regional office. In Sept. we implemented a check of the user's county/regional office affiliation with that of the client (matching the legal county and referral date on the face sheet). This is becoming problematic for retro-authorizations that cover services before the referral date. We will need to make another change to this logic. Until this system fix can be made, it is necessary for the County to change the referral/transfer date, the Program Eligibility date, and the client CCS Eligibility Start Date, in order to authorize a retroactive SAR. If you have any problems with this, call the Help Desk.

7. **Will HF-only ever populate on a SAR?**

   No.

8. **Who has the ability to override a 21-day NICU stay on a SAR?**

   Anyone with SAR OVERRIDE security can override the approved # of days for a hospital stay. We anticipate developing a NICU SCG at a future date.

9. **For inpatient rehabilitation and NICU admissions, to whom should the SAR be sent?**

   Send a SAR to the hospital for the number of inpatient days; send a separate physician SCG 01 SAR to the NICU or inpatient rehab. Medical Director.

10. **I noticed Baclofen tablets are on the formulary of drugs requiring separate authorization. I thought the tablets did not need a separate**

authorization--only "intrathecal" Baclofen. I instructed a pharmacy to use the physician's SCG 01 authorization for the Baclofen tablets and they said it would not go thru. I then sent them a separate SAR for the Baclofen tablets and it seems to have worked. Will Baclofen tablets now require a separate authorization? Is a fix possible to add Baclofen tablets to the 01 SCG?

Oral Baclofen should be covered in the 01 SCG, but it was inadvertently included with intrathecal Baclofen in the list of excluded drugs requiring a separate authorization. For now, issue a separate authorization for oral Baclofen. You will be notified in a *This Computes!* when the system has been fixed to include oral Baclofen in the 01 SCG.

11. Can you modify a SAR the next day?

No, because the day's SAR transactions are transmitted to EDS on a nightly basis. For now, you can only modify a pending or authorized SAR on the day it was issued. The only element that can't be changed on a pending or authorized SAR the same day is the provider. If you need to change a SAR that was issued on a prior day, you must cancel the first SAR, and issue another SAR with the correct information. The system fix to modify a SAR on a subsequent day will not take effect until early 2005.

12. Can SARs be issued for formula or TPN?

No. The web-based SAR system will not allow a specific SAR to be issued for formula or TPN. The physician's authorization will allow the pharmacy provider to bill for formula or TPN listed as a Medi-Cal benefit. Compound products only need a SAR if any one of the compound ingredients is listed on the restricted drug list; otherwise the physician's SAR will allow payment following Medi-Cal billing rules.

13. Can Synagis be authorized in the web-based SAR system?

For now, use the legacy system for authorizing Synagis until updated instructions are given in a This Computes!

14. Can a Mom's CIN be used on a claim form along with an infant's SAR number if the baby is less than 2 months old and Medi-Cal covered the birth?

Yes. However, if the mother's CIN is used, the claim will suspend for examiner review and may inadvertently be denied. The system will be fixed to allow the mother's CIN to be used without the need to suspend the claims for manual review.

Claims Processing

1. **Which number is more critical for payment of a claim through the E 47-automated SAR system, the SAR number or Medi-Cal provider number?**

   Both numbers are required. The SAR number needs to be placed on the claim because it must match the SAR number waiting at EDS that will match the claim to the authorization. The Medi-Cal provider number must be present on the authorization in order for the claim to be processed. In addition, if the Medi-Cal provider number used to bill the service is not the same as the provider number used to issue the SAR, that Medi-Cal provider number must appear on the claim as either the rendering provider number or the referring provider number, depending on who provides the service. However, it is not necessary to list the Special Care Center as the referring provider when billing services using a CCS SAR number.

2. **After June 30, 2004, will claims be denied if the CGP number is used rather than a Medi-Cal provider number?**

   Not necessarily. If the authorization was issued through the legacy system, a CGP number is adequate at this time. With an authorization issued through the web-based system, however, only a Medi-Cal provider number will work, regardless of the client's payment source. Medi-Cal provider enrollment applications can be downloaded from the Medi-Cal website: http://www.medi-cal.ca.gov/.

3. **Can the selection for the denial be reformatted to bullet form for easier selection?**

   Yes, we will modify.

4. **Which provider number (contract or non-contract) do we use for non-Medi-Cal beneficiaries?**

   The non-contract provider number is used for non-Medi-Cal beneficiaries.

5. **Our dependent county authorized a BMT for a straight CCS child under the new SAR system. Currently, we receive NO information on what EDS pays under the new SAR system, since all claims now go directly to EDS. How can we invoice the State for the 100% reimbursement without seeing the claims?**

   The MR-0-910 and 940 reports contain all CCS-only adjudicated claims without regard to whether the authorization was issued by the legacy system or as an enhanced SAR. You may claim the 100% funding in accordance with the procedures as outlined in CCS Numbered Letters 35-0994 and 15-0494. Ideally the required attachment cited in N.L. 35-0994

which documents the BMT costs claimed for 100% State funding should include photo copies of the MR-0-940 with the CCS claims highlighted.

6. **Is work being done to allow us to retrieve detailed paid claims information from Business Objects, to enable us to compare this data with the MR reports for accurate State invoicing?**

   Yes, you will be able to view detailed paid claims reports for your county through Business Objects (BO) by the end of this year. New BO reports will allow the user to profile paid claims by child or by provider.

7. **Will payment ever be linked to a CCS diagnosis in the new SARs system?**

   No.

8. **We received a request from Sutter Memorial Hospital for a critical care consult during an outpatient dental procedure we authorized at SMH. No provider auth. was generated for the specialist, as the Dentist was was authorized through Denti-Cal. Can the specialty consultant bill on the outpatient SMH auth?**

   If the specialty consultant requested authorization for specific procedures he would be performing, you could issue him a SAR for those service codes. Otherwise, you could issue him a SAR for the 01 SCG, which would cover the visit.

9. **Can a provider be reimbursed if the service code on the SAR does not match the code used for billing?**

   The claim may deny. If the code is incorrect, and the item or service is a Medi-Cal-listed benefit, the claim will be reviewed by the system against the correct code on file and will probably be denied for incorrect code. If the code is for an unlisted item, the claim will require "by report" documentation and suspend for manual review. Depending on the reviewer's interpretation, the claim may deny. This is why it is critical to obtain the correct codes from the provider requesting the service, or to have issued a SAR with a SCG, if appropriate.

Durable Medical Equipment, Medical Supplies

1. **Can you tell me what the different modifiers for durable medical equipment (DME) stand for?**

   Effective Nov. 1, there are modifier changes and deletions, making the original answer obsolete. Here are the new modifiers effective Nov. 1, also published in the Medi-Cal Allied Health Provider Manual DME Update.

Y2, Y3, Y5, Y8, Y9, YP are terminated.
Y1, Y6, Y7 remain but the word "DME" is removed from the description.
Y4 remains but reimbursement is calculated without regard to sales tax.

** When issuing a SAR for DME and DME accessories, be sure to include the appropriate modifier in the authorization. ALL claims for DME and DME accessories must include one of the following new modifiers.

NU: New modifier for new equipment purchase, including complete replacement of an owned item
RR: New modifier for equipment rental
RP: New modifier for repair and replacement parts for patient owned equipment

For additional information, please see www.medi-cal.ca.gov.

2. **When do you use the sales tax modifier for DME and if the modifier does not appear on the SAR, how will the provider know it was authorized?**

When a provider submits a SAR, they need to indicate whether the item is for purchase or rental. The appropriate modifiers are located in "This Computes" #64. The website for this modifier is listed in that note. We are in the process of modifying the system to include the modifier, however until this happens you should indicate in the remarks section of the authorization what modifier you have approved. If you fail to provide the dealer with this modifier for either rent or purchase on the SAR they may bill with a different modifier the claim will be denied.

3. **When issuing an authorization for a wheelchair or other medical supply that will be rented for more than one month, what amount do we use in the UNITS authorized field?**

The Units authorized must equal the number of months that the item will be rented, for example if the rental period will be for 6 months, the SAR authorization dates must cover 6 months (assuming of course that the eligibility period is longer than 6 months) and the Units would equal 6.

4. **I have a SAR for medical supplies and I am having trouble finding a code to fit the description of the request. What should I do?**

Do not guess at the codes. Request the correct code from the provider. If you try to guess, chances are, your guess will not match up with the provider claim and it will be denied. Also, you may be looking under medical supplies, when the item is actually considered DME. Medical supply codes are always a 4-digit number, followed or preceded by a/n alpha letter/s. Manufacturer codes are not necessary. A "This Computes" should be out shortly for more detail.

5. **The Provider Bulletin states that diabetic supply authorizations issued prior to Nov. 1 with the old Local Level Medi-Cal Codes will continue to be valid for claiming with those old codes until the authorization expires. However, does the same apply to PROVIDERS who are not pharmacies? If they are holding an authorization can they continue to dispense and claim after Nov. 1 until the authorization expires?**

   The authorization issued prior to November 1 will remain effective for both the old codes and the old provider types until it expires. Thereafter, a new SAR needs to be issued to contracted pharmacy providers only and using the new NDC/UPC codes listed for contracted diabetic supplies only. Claims for non-contracted products or providers other than pharmacies will be denied for dates of service on or after November 1 with authorizations issued on or after that date. Additional information can be found in *This Computes! #75* and in the Allied Health Provider Manual and Bulletins on the Medi-Cal web site: www.medi-cal.ca.gov. In addition, a N.L. will be published soon regarding the upcoming DME and diabetic supply code changes that will take effect November 1, 2004.

6. **Is it possible to include diabetic supplies in a SCG?**

   No. Medical supplies are not included in any of the SCGs. Diabetic supplies (including lancets, insulin syringes, and test strips) must be authorized separately from the SCG. We are exploring the possibility of developing a medical supply listing in the web-based system for commonly used diabetic medical supplies that may make authorization easier.

7. **Our procedure for completing "by report" SAR authorizations is to describe the "by report" codes in the "Special Instruction" area of the SAR authorization and select the "DME 'By-Report'..." pre-provided Special Instruction. This is achievable when there are only a few items and/or short descriptions, but when the items are extensive and complicated the task becomes very onerous for the PHNs. Are there any revised procedures to handle this type of request?**

   For the present time, continue listing all specialized parts for wheelchairs in the authorization narrative section, along with the code. The new wheelchair and DME-R codes, which will be available on November 1st, will ease part of the problem with authorizing complicated custom wheelchairs, etc. With these new codes, fewer items will have to go into the special instruction box. The new codes are available now in the Medi-Cal Allied Health Bulletins and the Provider Manual updates, at www.medi-cal.ca.gov.

   These code changes are scheduled to begin on November 1st. The new codes must be used if the date of service is on or after November 1st; use the old ones if the date of service is before November 1st. If you have

previously issued authorizations for these items that include dates of service on or after November 1, it will be necessary to issue new authorizations on November 1 using the new codes, as claims with the old Local Level Medi-Cal Codes for dates of service on or after November 1 will be denied.

8. **Can a pharmacy dispense syringes based on an authorization for insulin, or will a separate SAR be required for insulin syringes?**

   All CCS services except incontinence supplies require authorization, including insulin syringes. The Physician's SCG 01 does not cover medical supplies. Apparently some pharmacies did not request authorization for insulin syringes because they were billing directly to EDS under the Medi-Cal provision to allow direct billing up to a monthly reimbursement limit for medical supplies. This does not apply to CCS clients, and although the providers may be able to do this for CCS/Medi-Cal clients, they cannot for CCS-only clients. Therefore to assure consistency between payers and from one pharmacy to another, CCS should separately list and authorize insulin syringes using the applicable listed medical supply code and based on the quantity prescribed by the authorized physician.

9. **How are polycarbonate lenses to be authorized, and how many units are entered on the SAR?**

   The physician must specifically prescribe polycarbonate lenses and safety frames. CCS may authorize the lenses and safety frames with code V2799 with a quantity of 2 for the lenses and 1 for the frames. The only time a provider would order one lens is if the patient had a change in the prescription within 24 months in one eye only, or had one lens damaged to a significant degree that it would affect vision and need replacement. The optician then dispenses the glasses and claims to EDS by attaching a copy of the CCS authorization and the purchase invoice (for the lenses and safety frames) to the claim ("By-report" claiming). Code V2799 is a benefit of Medi-Cal code, which may be authorized by the county CCS program and does not require EPSDT-SS approval. The procedure is the same for those counties still using Prison Industries for their vision products. Prison Industries does not provide polycarbonate lenses. The provider must purchase polycarbonate lenses from a private lab.

Provider Issues

1. **Why won't the system allow us to issue a SAR to a group's Medi-Cal Provider number?**

   Authorizations can only be issued to individual paneled providers, if the provider is a member of a group the SAR must be issued to her/his individual Medi-Cal number, if they do not have one or it is in an inactive status they need to contact the Provider Enrollment Branch in DHS and request that a number be issued or reactivated as the case may be.

Information on provider enrollment can be obtained at: http://files.medi-cal.ca.gov/pubsdoco/Pubsframe.asp?hURL=/pubsdoco/prov_enroll.asp

2. **What can be done when the provider address listed on the SAR does not match the provider's current address?**

   Provider information listed in E47 is based on the most current information in the Provider Master File. In these instances, the provider has not updated their current information in the Provider Master file. The provider must submit a supplemental application to correct/update the appropriate address and provider information to Medi-Cal. This form is on the Medi-Cal website: www.Medi-Cal.dhs.ca.gov. Until this information is changed, the provider authorization must be hand addressed by the program. Encourage the provider to submit the supplemental application as soon as possible, as it will no doubt take some time for the Medi-Cal Provider Enrollment Section to make those changes. CMS Net will also be changed in the future to allow for address correction on an individual SAR, but this option will not however make a permanent change to the provider's address.

3. **Does a paneled specialist have to share the 01 SCG SAR with a non-paneled primary care physician?**

   By selecting the medical home from the SAR drop-down menu, a copy of the 01 SCG SAR may be printed and sent to the primary care physician, thus removing the need for the specialist to share the SAR.

4. **What is a pseudo-SAR?**

   There is no such thing as a "pseudo-SAR". Please don't use this term. To enable pharmacies to bill for prescriptions filled for a CCS client pursuant to a prescription written by a CCS-approved physician who may still be functioning under the legacy system, a county CCS program or a State Regional Office can issue a web-based SAR to the physician for an individual office procedure code with a duration of up to the current Program Eligibility period. This SAR can then be utilized by pharmacies filling prescriptions for the CCS client to bill through CALPOS, even though the physician may not yet be utilizing the web-based SAR.

Service Codes, Service Code Groupings

1. **What happens when we need to authorize something that is out of the service code groupings (SCG)?**

   Currently, only the SCG 01 and SCG 07 SARs allow the authorization of additional service codes on the same SAR. Until a system fix has been implemented allowing the authorization of additional services on the SCC SAR(s), either create additional SARs for those services, or add the

additional service codes to a SCG 01 or SCG 07, as applicable. Remember though, CPT codes can only be used by physicians or billed by hospitals. A SAR authorizing a CPT code (not already included in a SCG) cannot be issued directly to an Allied Health Provider.

2. **I can locate service codes for the NICU but I am unable to locate service codes for the PICU. What can I do for the PICU authorizations?**

   Though the codes for NICU are listed as NICU, they are designed for use in both CCS-approved NICUs and PICUs.

3. **When a SCG authorization is issued to a Communications Disorder Center (SCC), individual codes CANNOT be authorized on the same SAR. Correct?**

   Correct. The fix allowing the authorization of individual codes on the SCG SAR for SCCs will not take place until the November or December change cycle. Counties will be notified when this change has occurred in a This Computes.

4. **For codes within SCG 04 that are EPSDT SS, do you check the EPSDT SS box?**

   No. SCG SARs are neither EPSDT SS, nor CCS SS.

DENTAL

Authorizations

1. **When authorizing updated orthodontia services that were previously authorized in the legacy system, is it necessary to continue a CCS child's orthodontia authorization in the legacy system, or can a new authorization be given in the SAR system?**

   Orthodontia authorizations must be continued in the legacy system, since the provider may have been issued an authorization under a CGP number rather than a Denti-Cal Provider Number. If a new authorization for orthodontia is needed, it should be initiated in the SAR system using the provider's Medi-Cal or Denti-Cal provider number, as described above.

2. **For the child who needs dental services prior to cardiac surgery, will the Denti-Cal program handle this request urgently or does the surgery need to be canceled to complete the dental work?**

   We have discussed this type of issue with Dr. Brian Quattlebaum, chief dental consultant of the Denti-Cal program, who believes that Medi-Cal regulation recommends proceeding with necessary services and indicating on the authorization the following information: " CCS Patient-Retroactive

Prior Authorization Requested". If the dental provider is uncomfortable with that solution, the provider may call Dr. Quattlebaum at Denti-Cal and speak with him directly.

3. **Who is responsible for the authorization of anesthesia for dental services authorized by Denti-Cal for CCS clients?**

   The CCS program should authorize the anesthesia and any other medical services to support the dental services. Even if you do not know about the initial authorization of these services by Denti-Cal, the dentist will need to work with the hospital to obtain a separate authorization from CCS for the anesthesia services, as well as either inpatient or outpatient hospital services.

4. **When we select a dentist, sometimes there is no address showing up on the SAR. What causes this?**

   The process to remove a dentist from the Denti-Cal Provider List involves two steps. 1) Denti-Cal removes the provider's address from the file; and 2) The provider's active status is removed at a later date. If you select a dentist without a corresponding address, you should NOT issue any SAR's to them, as Denti-Cal will deny any claims that are submitted related to that provider. We are making a change in CMS Net to prevent this from occurring, but for now, select another dentist.

5. **We are trying to authorize to a dentist, but cannot find the Provider Number in the system. The dentist is a member of a dental group, such as Western Dental. What can we do?**

   At this point, we can only issue authorizations to dentists who have active individual numbers. However, we are in the process of changing CMS Net to allow authorizations to what would be referred to as a dental group. We will send out a *This Computes* when this happens.

6. **I'm trying to do a SAR for inpatient dental surgery to UCSF Ambulatory Care Center for a CCS child with full scope Medi-Cal with a diagnosis of Cerebral Palsy. As I understand it, the provider will send the claim/TAR to Delta Dental for the dental procedure without a SAR. I should authorize the SAR for the general anesthesia and operating room facilities, right? The problem is, the provider and I do not know what procedure code to put on the SAR for "operating room facilities". Do you know?**

   The Rates: Maximum Reimbursement section of the Medi-Cal provider manual describes Hospital Outpatient rates and procedure codes for emergency, examining, and treatment rooms and related Departments. For further information, see www.medi-cal.ca.gov. This was also previously

published in *This Computes! #71.* These procedure codes are not reimbursable to community clinics, free clinics, county-operated organized outpatient clinics, Rural Health Clinics and other organized outpatient clinics unless the clinics are enrolled in the Medi-Cal program as an organized outpatient clinic with surgical facilities, as defined in CCR, Title 22, Section 51115(b).

7. **If Denti-Cal is directly authorizing complex cases such as a child with cardiac anomalies needing basic dental work, or a child with a cleft palate needing orthodontia work, is the family still eligible for Maintenance and Transportation (M&T) benefits?**

   If the child is medically eligible for CCS and you would have authorized the dental services in the past, as related to or impacting the CCS eligible condition, the child should be eligible for M&T benefits if needed. Even though you might not be authorizing the actual dental work, Denti-Cal is doing so and acting as our designee for these clients.

Provider Issues

1. **How can we get the list of Denti-Cal providers? Will the providers who did not want their name used for referrals be on the list?**

   All of the active Denti-Cal providers will listed be on the Provider Master File that is in E 47. However, they may not be taking new patients and you should contact them prior to issuing authorizations.

2. **Regarding oral surgery performed within a hospital setting, does the oral surgeon bill with his Denti-Cal or a Medi-Cal provider number?**

   If the oral surgeon is both a DDS and an M.D., it is the oral surgeon's choice whether to bill under the Denti-Cal Provider Number or the Medi-Cal Provider Number. Authorization must be requested under the specific provider number that will be used. The hospital still needs an authorization for the number of hospital inpatient days.

3. **When an orthodontist sends a CCS child elsewhere to get x-rays or labs done, how does the x-ray or lab provider get paid if they don't have a Denti-Cal provider number?**

   Have the orthodontist cover the charges for the x-ray or lab provider, then bill Denti-Cal for those charges on his own claim so he can be reimbursed.

Service Code Groupings

1. **When will Dental service code groupings (SCG) be on the website?**

   The Dental SCGs are currently posted on the CMS website. All dental codes begin with "S". Any authorization for the dental SCG must have the S

preceding the number 01-18. The Denti-Cal Unit has published the instructions to dentists in the September Provider Bulletin. To obtain a manual, call provider services at 1-800-423-0507 at Denti-Cal. There is a small fee that will cover that cost. A Denti-Cal provider will automatically receive a manual.

POLICY

Authorizations

1. How do I authorize vendored therapy (OT/PT) services in lieu of MTU?

If the paneled OT/PT is at an outpatient center/hospital, the agency they work for should already have an active Medi-Cal provider ID number, and you can use the SAR system. The Medi-Cal provider number for the facility should be for an outpatient community hospital or outpatient county hospital. In the special instructions section, the paneled provider OT/PT should be listed.
You can use this procedure for both therapy in lieu of MTU and for therapy services under the treatment program.

If the paneled OT/PT is a private practitioner and has an active Medi-Cal provider number but the number is under the business name, you cannot currently use the SAR system. You will have to use the legacy system. For now, you will need to use this procedure for both therapy in lieu of MTU and for therapy services under the treatment program.

If the paneled OT/PT is a private practitioner and has an active Medi-Cal provider number issued in his/her name and not to a business name, you can use the SAR system.

When using the SAR system and the services are for therapy in lieu of MTU all authorizations should be provided by the local program as an EPSDT SS benefit for a child with full scope Medi-Cal and no share of cost.

When using the SAR system for therapy services under the treatment program for a child with full scope Medi-Cal and no share of cost, prior state approval is still required for EPSDT SS for services, which exceed the Medi-Cal limits

2. How do I authorize Prosthetics and Orthotic (P&O) services?

Most P&O facilities already have an active Medi-Cal provider ID number. The authorization can be issued to the facility through the SAR system, if they have the Medi-Cal provider number and have been approved by the Branch. In special instructions, the paneled orthotist or prosthetist should be listed. If the facility does not show up on the SAR system, use the legacy

system for now, but contact the Provider Services Unit and advise them of the provider as they may be able to approve them for SAR issuance.

3. **How do we authorize the co-payment for patients with CCS and PPO coverage?**

   Co-payments are not authorized the services associated with them are, the provider bills EDS for the services following instructions in the Medi-Cal Provider Manuals. However, at the discretion of the administrator, the county can work with the provider at the time of the authorization to obligate the share of cost. Previously, in these instances the county worked with the provider at the time of billing.

4. **For an inpatient hospitalization involving surgery, will all professional fees be covered with the SAR authorizing the specific surgical procedure?**

   Yes, if the SARs are issued as follows: 1) the hospital SAR for the number of inpatient days; and 2) the 01 SCG SAR to the surgeon so that hospital visits and other physician services will be covered, adding the applicable surgical procedure codes on the same SAR. Other consulting physicians will be able to use the surgeon's 01 SCG for claiming.

Provider Issues

1. **Do emergency room doctors need to get paneled and if the patient is hospitalized do the services from the ER get billed through the hospital authorization?**

   Emergency room services are billed through the hospital if the patient is admitted. If not, there will be a bill from the emergency room and from the physician's group that serves the hospital ER department. If the physician is not paneled or the hospital approved the emergency paneling procedure for both the hospital and provider through E 47 can be utilized. You may call the Provider Services Unit (PSU) at (916) 327-8702, for assistance with emergency paneling. This system can be used when the hospital bills for the physician services as well.

2. **If the address for the paneled provider in a group is incorrect how will it be fixed and where should we send the SAR approval?**

   CMS Net uses the provider file for the Medi-Cal program; information on a providers file can only be changed at the request of the provider to the Provider Enrollment Branch in DHS. The provider needs to contact the Enrollment Branch and request an address correction http://files.medi-cal.ca.gov/pubsdoco/Pubsframe.asp?hURL=/pubsdoco/prov_enroll.asp. It is important to note however that the address need not be the address of the

group; it can be any address the provider chooses. As long as the provider gets his/her copy of the SAR authorization it is up to them to share it with the Group practice where the service will be performed. Until the address correction is effective you will need to hand address the SAR approval to the address the provider supplies to you. We are researching the possibility of modifying the CMS Net system to allow you to modify the mailing address on individual authorizations, however this will not eliminate the need for the provider to make the formal correction with the Enrollment Branch.

3. **What should we tell pharmacies who cannot process claims for children with Healthy Families coverage?**

   We are currently working with EDS to correct this problem, however in the interim the Pharmacy has the ability to override the other coverage restriction on a case-by-case basis. They should use this authority when the prescription is from the physician who was issued the SAR. If they wish they could verify with the physician that the prescription is for the CCS eligible condition but that is not required.

4. **Concerning a FAQ from a prior publication: "Provider address listed on the SAR does not match the provider's current address." What action should be taken?**

   To clarify, it is necessary to have the provider complete a Medi-Cal supplemental application only for a change to the pay-to-address. If the provider has a change in the service address, an entire new application is required. We will be making a change in CMS Net to allow the address on individual SARs to be changed, however this will not correct the provider's address in the system. Until the provider requests the change from Medi-Cal, the address will continue to come up incorrectly on the SAR and require manual correction by the Case Manager.

5. **What is the status of stand-alone Emergency Room (ER) and outpatient facility codes?**

   Outpatient facility codes will be added to the existing SCGs. A separate Emergency SCG is being considered to address ER visits that do not result in an admission to the hospital.

6. **Is paneling required for Prosthetists and Orthotists?**

   Yes.

7. **We have discovered that although an Individual Nurse Provider (INP, either a RN or LVN) has an active EPS Medi-Cal enrolled Provider Number and is listed in the CMS web-based system as a provider to choose from, these SARs cannot be authorized because these nurses**

are not "Paneled." Is there something we can do?

CCS has traditionally issued legacy authorizations for INPs on behalf of IHO for CCS children enrolled in a Medi-Cal Managed Care Plan. Historically, CCS has never required independent nurses to be paneled. Nurses, along with all members of the SCC team however, do require paneling. When nurses (shift nurses or otherwise) are employed by a home health agency (HHA), paneling is not required. INPs are usually used when there are no HHAs in the area or the HHA cannot staff a case and there is/are an independent nurse/s who is/are willing to provide the service.

For now, INP authorizations should be continued in the legacy system until a solution can be determined. You will be notified in a This Computes! when updated instructions are available.

Service Code Groupings

1. **Service Code Groupings are very broad. How will we be certain that they are not being abused?**

   Business object reports are under development now and will allow counties to look at utilization of services to determine if paid claims data indicate any fraudulent trends. More information will be issued on this later and counties will likely assist with refining the elements that will be used on these reports.

2. **Can a descriptive sentence be added to describe each Service Code contained in a SGC?**

   No. Abbreviated descriptions are copy-written and each county should be obtaining CPT Code books and HCPCS Level II books to correspond with annual updates for referencing and determining the description. That being said, providers should be giving you codes for specific services if you are not authorizing broad categories such as service code groupings. If the provider gives you a code that does not register when placing it in the SAR system, it means that it is not a current code. Rather than trying to figure out what the provider meant, they should be informed and asked to submit a different code.

3. **How can a MRI be authorized to the imaging center providing the service?**

   There are currently no MRI codes contained within the 01 SCG. If the prescribing physician is not a member of a SCC, issue a SAR with the specific MRI code(s) to the prescribing/referring physician, along with a 01 SCG SAR for his services (if not already issued). The physician, in turn, sends the MRI authorization to the imaging center, along with the referral for the MRI.

Most MRI codes are contained within the 02 SCG. If the physician prescribing the MRI is a member of a SCC, the 02 SCG SAR should be shared with the imaging center to cover the MRI. If the code for the MRI is not contained in the 02 SCG, issue a SAR with the specific MRI code(s) to the prescribing/referring physician. The physician, in turn, sends this SAR to the imaging center, along with the referral for the MRI.

4. **Can a separate SAR for SCG 04 and another SAR for SCG 05 be issued to two different centers if applicable for the child, i.e. the SCG 04 to a local CDC, and the SCG 05 to a cochlear implant center?**

   All the service codes contained in SCG 04 are also contained in SCG 05. If the cochlear implant center is also the child's CDC, then a SCG 05 to the center will be sufficient. However, if the child has a local CDC and a regional cochlear implant center, issue a SCG 04 to the CDC and a SCG 05 to the cochlear implant center.

5. **Does a SCG 02 SAR include the provision of a sleep study?**

   Sleep study CPT codes 95806-95807 are included in SCG 02.